

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017517

STATE FILE NUMBER

FILED MAY 26 1959

Registration District No.

139

Primary Registration District No.

Registrar's No.

21

300
1-57

1. PLACE OF DEATH a. COUNTY <u>HOLT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>HOLT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>MOUND City</u>		c. CITY OR TOWN <u>MOUND City</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <u>3 yrs.</u>	
3. NAME OF DECEASED (Type or print) <u>RAYMOND FRANKLIN GELVIN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 3. WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 25, 1915</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		11. BIRTHPLACE (City and state or country) <u>MOUND City, Mo.</u>	
13a. FATHER'S NAME <u>SAMUEL L. GELVIN</u>		13b. MOTHER'S MAIDEN NAME <u>MINA PATTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>566-07-8720</u>	
17. INFORMANT <u>SAM GELVIN</u>		Address <u>MOUND City, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Congestive heart Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>Unknown</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>6</u> a.m. Month, Day, Year <u>July 1, 1956</u>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>MOUND City</u>	
21. I attended the deceased from Death occurred at <u>6 A.M.</u>		21. I attended the deceased from last saw him alive on <u>May 16, 1959</u>	
22a. SIGNATURE (Degree or title) <u>Joan F. Sweeney M.D.</u>		22b. ADDRESS <u>Oregon, Missouri</u>	
22c. DATE SIGNED <u>5/17/59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>MAY 19, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT HOPE</u>	
23d. LOCATION (City, town, or county) <u>MOUND City, Mo.</u>		24. FUNERAL DIRECTOR <u>James H. Crawford</u>	
25. DATE REC'D. BY LOCAL REG. <u>5/17/1959</u>		26. REGISTRAR'S SIGNATURE <u>James H. Crawford</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *James H. Crawford*

Licensed Embalmer No. *4796*.....
P. O. Address *Mound City,*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.